IN THE UNITED STATES DISTRICT COURT FOR THE
WESTERN DISTRICT OF MISSOURI
WESTERN DIVISION

MARY KUHL, et al,	)	
Plaintiffs,	)	
	)	
v.	)	No.
LINCOLN NATIONAL HEALTH PLAN OF KANSAS CITY, INC.,	)	91-0330-CV-W-9
Defendant.	)	
	)	

ORDER DENYING PLAINTIFFS' MOTION TO REMAND AND GRANTING DEFENDANT'S MOTION FOR SUMMARY JUDGMENT

(Filed Dec. 26, 1991)

I. Introduction

On March 15, 1991, plaintiffs Mary Kuhl, Buddy Kuhl, Jr. and Marnie K. Kuhl filed their Petition in the Circuit Court of Jackson County, Missouri, asserting four claims against defendant Lincoln National Health Plan of Kansas City, Inc. (Lincoln National): medical malpractice, emotional distress, tortious interference with decedent Buddy L. Kuhl, Sr.'s right to contract for medical care and breach of a contract of which Buddy Kuhl Sr. was a third-party beneficiary.

On April 11, 1991, defendant filed its Notice of Removal pursuant to 28 U.S.C. § 1441(b), stating that federal question jurisdiction exists over plaintiffs' claims because the Employee Retirement Income Security Act of

1974 (ERISA), 29 U.S.C. § 1001, *et seq.*, preempts each claim.

On May 14, 1991, plaintiffs moved to remand this case to the Circuit Court of Jackson County, Missouri, because no federal question appears on the face of the Complaint and the case is not otherwise removable based on the "complete preemption doctrine."

On June 10, 1991, defendant moved for summary judgment arguing that plaintiffs' claims are preempted by ERISA.

II. Facts

Lincoln National Health Plan is a health insurance organization which contracted with Belger Cartage Services, Inc. (Belger) to administer a Group Medical Plan provided by Belger to its employees. Because Lincoln National Health Plan is an "independent physician" HMO, it does not have doctors or nurses on staff who render medical services. Instead, it pays independent physicians, hospitals and other health care providers for rendering medical services to members.

Pursuant to the contract between Lincoln National Health Plan and Belger, Lincoln National pays for medical services provided to Belger employees according to the restrictions, limitations and exclusions set forth in the contract. Lincoln National is not obligated to automatically pay for medical services rendered outside the "Service Area" of the Lincoln National network or for medical services rendered by doctors not participating in the Lincoln National network. All decisions concerning payment

of claims or benefits under the Plan were the responsibility of Lincoln National.

Lincoln National conducts a "pre-certification" review of hospital admissions. In the pre-certification review, Lincoln National determines whether a particular procedure or hospitalization is covered by the Plan.

The Belger Group Medical Plan is an "employee benefit plan" and an "employee welfare benefit plan" within the meaning of ERISA.

Buddy Kuhl was an employee of Belger. As of March 1, 1989, Buddy Kuhl had opted to receive medical benefits under the Plan administered by Lincoln National.

On April 29, 1989, Buddy Kuhl suffered a heart attack. With the approval of Dr. Virginia Grimes, Buddy Kuhl's designated primary care physician, Buddy Kuhl was placed in the care of Dr. Bernard Levi, a heart specialist at Menorah Medical Center. Dr. Levi concluded that heart surgery would be necessary, including open heart LV aneurysmectomy and coronary by-pass surgery. This recommendation was confirmed by Dr. Ahuja in a May 23, 1989, letter stating that Buddy Kuhl was a "candidate for sudden death" and needed the recommended surgery "in the next few weeks."[1] Lincoln National received a copy of this second opinion.

On June 8, 1989, Dr. Levi wrote a letter to Dr. Grimes informing her that Buddy Kuhl would be readmitted to Menorah for observation and electrophysiological testing on June 15, 1989, to determine whether Buddy Kuhl had

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[1] Lincoln National arranged for the second opinion rendered by Dr. Ahuja.

inducible ventricular tachycardia. Dr. Levi stated that if he determined that Buddy Kuhl suffered from that condition, he would strongly recommend consultation with Dr. James Cox of Barnes Hospital in St. Louis for formal electrophysiological guided left ventricular aneurysm resection and subendocardial resection as well as bypass surgery.

Between June 13, 1989, and June 16, 1989, Buddy Kuhl underwent extensive tests at Menorah to determine the extent of the heart damage and to determine the proper course of treatment. Dr. Levi instructed Buddy Kuhl that the best course was to have bypass surgery and an aneurysm removal. On June 20, 1989, Dr. Levi determined that Buddy Kuhl would have the best chance of survival if the surgery were performed at Barnes Hospital in St. Louis, Missouri. Dr. Levi concluded that Kansas City area hospitals did not have the equipment to perform the technically advanced computerized surgery and the surgeons at Barnes were more experienced and successful than any doctor in Kansas City. Therefore, arrangements were made for Dr. Cox, a heart surgeon specializing in computerized cardiac mapping and bypass surgery on patients with ventricular tachycardia, to perform the surgery at Barnes Hospital on July 6, 1989. Dr. Hannah, a cardiac surgeon at Menorah and a participating provider under the Plan, agreed with Dr. Levi's determination that Buddy Kuhl's best interests would be served by having Dr. Cox perform the surgery at Barnes.

On June 20, 1989, Dianne Long, a utilization review coordinator for Lincoln National, received a telephone call from Barnes Hospital. Barnes Hospital informed Long that surgery had been scheduled for July 6, 1989,

and requested pre-certification review. On June 23, 1989, Lincoln National refused to certify benefits for the surgery because Barnes Hospital was outside the Lincoln National "Service Area." The surgery was cancelled.

Lincoln National scheduled a July 6, 1989, appointment for Buddy Kuhl to see Dr. Brodine at Research Medical Center in Kansas City to determine whether the surgery could successfully be performed in Kansas City rather than in St. Louis. Dr. Brodine concurred with Dr. Levi's recommendation that the heart surgery should be performed by Dr. Cox in St. Louis due to the availability of technically advanced computerized cardiac mapping facilities at Barnes Hospital. Dr. Brodine informed Dianne Long of his opinion on July 6, 1989.

On July 20, 1989, Lincoln National informed Buddy Kuhl that it would authorize the surgery at Barnes Hospital. Buddy Kuhl immediately contacted Barnes Hospital to reschedule the surgery. He was informed that the surgery could not be performed until September 1989, due to the unavailability of the surgical team.

Buddy and Mary Kuhl traveled to St. Louis on September 2, 1989, in anticipation of surgery. However, based on tests conducted prior to the surgery, Dr. Cox found that Buddy Kuhl's heart had deteriorated to such an extent that "[he] no longer felt [Buddy Kuhl] was a reasonable operative candidate." Dr. Cox recommended that Buddy Kuhl be evaluated for cardiac transplantation "because that [was] really the only thing left to offer."

The physicians at Barnes asked that additional testing be conducted and that Buddy Kuhl be placed on a heart transplant waiting list at Barnes Hospital. Lincoln

National refused to pre-certify payment of these medical costs. However, Buddy Kuhl was placed on a heart transplant waiting list at Kansas University Medical Center.

While waiting for a heart transplant, Buddy Kuhl died due to ventricular tachycardia on December 28, 1989.

II. Applicable Standards

A. Standard for Remand

Title 28 U.S.C. § 1447(c), Federal Rules of Civil Procedure, which governs motions to remand, provides:

> A motion to remand the case on the basis of any defect in removal procedure must be made within 30 days after the filing of the notice of removal under section 1446(a). *If at any time before final judgment it appears that the district court lacks subject matter jurisdiction, the case shall be remanded.* An order remanding the case may require payment of just costs and any actual expenses, including attorney fees, incurred as a result of the removal. A certified copy of the order of remand shall be mailed by the clerk to the clerk of the State court. The State court may thereupon proceed with such case.

B. Standard for Summary Judgment

Rule 56(c), Federal Rules of Civil Procedure, provides that summary judgment shall be rendered if the "pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show

that there is no genuine issue as to any material fact and that the moving party is entitled to judgment as a matter of law." In ruling on a motion for summary judgment, it is the court's obligation to view the facts in the light most favorable to the adverse party and to allow the adverse party the benefit of all reasonable inferences to be drawn from the evidence. *Adickes v. S. H. Kress & Co.*, 398 U.S. 144, 157, 90 S. Ct. 1598, 1608 (1970); *Inland Oil and Transport Co. v. United States*, 600 F.2d 725, 727-28 (8th Cir.), *cert. denied*, 444 U.S. 991, (1979).

If there is no genuine issue about any material fact, summary judgment is proper because it avoids needless and costly litigation and promotes judicial efficiency. *Roberts v. Browning*, 610 F.2d 528, 531 (8th Cir. 1979); *United States v. Porter*, 581 F.2d 698, 703 (8th Cir. 1978). The summary judgment procedure is not a "disfavored procedural shortcut." Rather, it is "an integral part of the Federal Rules as a whole." *Celotex Corp. v. Catrett*, 106 S. Ct. 2548, 2555 (1986); *see also City of Mt. Pleasant v. Associated Electric Cooperative. Inc.*, 838 F.2d 268, 273 (8th Cir. 1988). Summary judgment is appropriate against a party who fails to make a showing sufficient to establish that there is a genuine issue for trial about an element essential to that party's case, and on which that party will bear the burden of proof at trial. *Celotex*, 106 S. Ct. at 2553.

The moving party bears the initial burden of demonstrating by reference to portions of pleadings, depositions, answers to interrogatories and admissions on file, together with affidavits, if any, the *absence* of genuine issues of material fact. However, the moving party *is not required* to support its motion with affidavits or other

similar materials *negating* the opponent's claim. *Id.* (emphasis added).

The nonmoving party is then required to go beyond the pleadings and by affidavits, depositions, answers to interrogatories and admissions on file, designate specific facts showing that there is a genuine issue for trial. *Id.* A party opposing a properly supported motion for summary judgment cannot simply rest on allegations and denials in his pleading to get to a jury without any significant probative evidence tending to support the complaint. *Anderson v. Liberty Lobby, Inc.*, 106 S. Ct. 2505, 2510 (1986).

A genuine issue of material fact exists "if the evidence is such that a reasonable jury could return a verdict for the nonmoving party." *Id.* The evidence favoring the nonmoving party must be more than "merely colorable." *Id.* at 2511. When the moving party has carried its burden under Rule 56(c), its opponent must do more than simply show there is some metaphysical doubt as to the material facts. *Matsushita Elec. Indus. Co. v. Zenith Radio*, 106 S. Ct. 1348, 1356 (1986) (footnote omitted).

The inquiry to be made mirrors the standard for a directed verdict: whether the evidence presented by the party with the onus of proof is sufficient that a jury could properly proceed to return a verdict for that party. *Anderson v. Liberty Lobby* at 2511. Essentially, the question in ruling on a motion for summary judgment and on a motion for directed verdict is whether the evidence presents a sufficient disagreement to require submission to a jury or whether it is so one-sided that one party must prevail as a matter of law. *Id.* at 2512.

III. Discussion

Plaintiffs' Motion to Remand and Defendant's Motion for Summary Judgment Will Be Denied Because Plaintiffs' Claims are Preempted by ERISA

Title 28 U.S.C. § 1441(a) provides that "any civil action brought in a State court of which the district courts of the United States have original jurisdiction, may be removed by the defendant or defendants." District courts have original jurisdiction over "federal question" cases; that is, those cases "arising under the Constitution, laws, or treaties of the United States." See 28 U.S.C. § 1331. A case "arises under" federal law only when the plaintiff's well-pleaded complaint raises issues of federal law. *See Gully v. First Nat'l Bank*, 299 U.S. 109, 112-13, 57 S. Ct. 96, 97-98 (1936). The United States Supreme Court has adhered to the "well-pleaded complaint rule" even where a plaintiff's state law claim is preempted by federal law:

> [I]t is now settled law that a case may *not* be removed to federal court on the basis of a federal defense, including the defense of preemption, even if the defense is anticipated in the plaintiff's complaint, and even if both parties concede that the federal defense is the only question truly at issue.

Caterpillar Inc. v. Williams, 482 U.S. 386, 393, 107 S. Ct. 2425, 2430 (1987) (citation omitted).

One important exception to the well-pleaded complaint rule is that Congress may so completely preempt a particular area of state law that any civil complaint raising this select group of claims is necessarily federal in

character and, therefore, subject to removal. *Metropolitan Life Ins. Co. v. Taylor,* 481 U.S. 58, 63-64, 481 S. Ct. 1542, 1546 (1987).

In *Franchise Tax Board v. Construction Laborers Vacation Trust,* 463 U.S. 1, 25, 103 S. Ct. 2841, 2854 (1983), the Supreme Court concluded that ERISA does not completely preempt all state law claims: "Congress did not intend to pre-empt entirely every state cause of action relating to such plans [plans covered by ERISA]." However, ERISA may preempt the corresponding area of state law in such a decisive manner that a state law claim would be considered to arise under federal law. *See id.* at 24, 103 S. Ct. at 2854.

The mere fact that a state claim is preempted by ERISA, without more, does not convert the state claim into an action arising under federal law. *Id.* at 25-27, 103 S. Ct. at 2854-56; *see also Metropolitan Life,* 481 U.S. at 64, 107 S. Ct. at 1547. However, a preempted state claim that also comes "within the scope of § 502(A) of ERISA would be removable to federal district court even if an otherwise adequate cause of action were pleaded without reference to federal law."[2] *Franchise Tax Board,* 463 U.S. at 24-25, 103 S. Ct. at 2854-56.

In *Metropolitan Life,* 481 U.S. at 66, 107 S. Ct. at 1548, the Supreme Court stated:

> Congress has clearly manifested an intent to make causes of action within the scope of the civil enforcement provisions of § 502(a) [29

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[2] Section 502(a), 29 U.S.C. § 1132(a), is set forth *supra* pp. 16-17.

> U.S.C. § 1132(a)] removable to federal court. . . . [T]hough it purports to raise only state law claims, [this suit] is necessarily federal in character. . . . It, therefore, arise[s] under the . . . laws . . . of the United States, . . . and is removable to federal court by the defendants. . . .

Thus, to determine whether plaintiffs' case is properly removable to federal court, I must first determine whether the claims asserted by plaintiffs, which are state common-law claims, are preempted by ERISA. Secondly, I must determine whether plaintiffs' claims are "within the scope of § 502(a)" of ERISA, thereby converting the state law claims to claims "arising under" federal law.

1. Plaintiffs' Claims are Preempted by ERISA

ERISA is a remedial statute through which Congress established a comprehensive federal scheme to regulate the creation and administration of employee benefit plans. *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 44, 107 S. Ct. 1549, 1551 (1987).[3] ERISA is designed to protect the interests of employees in obtaining vested benefits under established pension and welfare plans by imposing requirements on employers for reporting, disclosure, participation rights, vesting of rights to benefits, funding, fiduciary responsibilities and claims procedures. *Scott v.*

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[3] The term "employee benefit plan" broadly includes any plan, fund or program maintained for the purpose of providing employees with a wide spectrum of benefits such as pension, medical, accident, disability, death, unemployment, or vacation benefits. *See* 29 U.S.C. § 1002(1).

Gulf Oil Corp., 754 F.2d 1499, 1501 (9th Cir. 1985) (citing *Shaw v. Delta Airlines, Inc.*, 463 U.S. 85, 103 S. Ct. 2890 (1983)); *see also* 29 U.S.C. § 1021-1145. ERISA protects employers from inconsistent state and local regulation of such plans by an express provision preempting all state laws that "relate to" employee benefit plans. *Id* (citing § 514(a) of ERISA, 29 U.S.C. § 1144).

Section 514(a) of ERISA states:

> Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede *any and all State laws insofar as they may now or hereafter relate to any employee benefit plan* described in section 1003(a) of this title and not exempt under section 1003(b) of this title. . . .

28 U.S.C. § 1144(a) (emphasis added). "The question of whether a certain state action is preempted by federal law is one of congressional intent." *Pilot Life Ins.*, 481 U.S. at 45, 107 S. Ct. at 1552 (citations omitted); *FMC Corp. v. Holliday*, 111 S. Ct. 403, 407 (1990).

In *Pilot Life*, the plaintiff asserted contract and tort claims under common law for the alleged improper processing of a claim for benefits under an employee benefit plan. The Supreme Court concluded that ERISA preempts all state common law causes of action that assert improper processing of claims under a benefit plan regulated by ERISA. *Id.* at 47, 107 S. Ct. at 1553. ERISA's preemption provision is not limited to state laws that are specifically designed to affect employee benefit plans but extends to common law causes of action as well. *Id.* at 46, 107 S. Ct. at 1553. The ERISA preemption provision is

"deliberately expansive, and designed to 'establish pension plan regulation as exclusively a federal concern.' " *Id.* at 46, 107 S. Ct. at 1552 (citations omitted); *Ingersoll-Rand Co. v. McClendon*, 111 S. Ct. 478, 482 (1990).

The phrase "relates to" in § 514(a) must be given its "broad common-sense meaning." *Pilot Life*, 481 U.S. at 47, 107 S. Ct. at 1553 (quoting *Metropolitan Life*, 471 U.S. at 739, 105 S. Ct. at 2389). A state law " 'relates to a benefit plan in the normal sense of the phrase, if it has a connection with or reference to such a plan.' " *Id.* (quoting *Metropolitan Life*, 471 U.S. at 739, 105 S. Ct. at 2389 and *Shaw*, 463 U.S. at 97, 103 S. Ct. at 2900).

In *Ingersoll-Rand Co.*, the plaintiff asserted a state common law claim alleging that he was "unlawfully discharged to prevent his attainment of benefits under a plan covered by ERISA." 111 S. Ct. at 481. The Supreme Court again emphasized that preemption under § 514(a) should be applied expansively. The Supreme Court concluded:

> We have no difficulty in concluding that the cause of action which the Texas Supreme Court recognized here – a claim that the employer wrongfully terminated plaintiff primarily because of the employer's desire to avoid contributing to or paying benefits under the employee's pension fund – 'relate[s] to' an ERISA-covered plan within the meaning of § 514(a), and is therefore pre-empted.

Id. at 483.

Although preemption under ERISA is very broad, the Supreme Court has observed that "[s]ome state actions may affect employee benefit plans in too tenuous, remote,

or peripheral a manner to warrant a finding that the law "relates to" the plan. *Shaw*, 463 U.S. at 100 n.21, 103 S. Ct. at 2901 n.21; *see also Mackey v. Lanier Collections Agency & Serv., Inc.*, 108 S. Ct. 2182, 2187 (1988) ("[L]awsuits against ERISA plans for run-of-the-mill state-law claims such as unpaid rent, failure to pay creditors, or even torts committed by an ERISA plan" are not preempted by ERISA); *Settles v. Golden Rule Ins. Co.*, 927 F.2d 505, 509 (10th Cir. 1991); *Howard v. Parisian, Inc.*, 807 F.2d 1560, 1564 (11th Cir. 1987); *see, e.g., Aetna Life Ins. Co. v. Borges*, 869 F.2d 142, 145 (2d Cir.), *cert. denied*, 493 U.S. 811 (1989) (Connecticut escheat law not preempted); *Sommers Drug Stores Co. Employee Profit Sharing Trust v. Corrigan Enterprises, Inc.*, 793 F.2d 1456, 1465-70 (5th Cir. 1986) (corporate officer's fiduciary duties to shareholders not preempted simply because employee benefit plan is shareholder); *Lane v. Goren*, 743 F.2d 1337, 1339-41 (9th Cir. 1984) (state anti-discrimination laws apply to employees of benefit plan); *Bowen v. Bowen*, 715 F.2d 559, 560-61 (11th Cir. 1983) (per curiam) (garnishment of spouse's benefit plan income to enforce maintenance award not preempted); *American Tel. & Tel. Co. v. Merry*, 592 F.2d 118, 121 (2d Cir. 1979) (state garnishment of spouse's pension income to enforce maintenance and support orders not preempted).

Claims based on state common-law doctrines that do not explicitly refer to employee benefit plans are nonetheless preempted when the claims *arise from the administration of such plans. See, e.g., Settles v. Golden Rule Ins. Co.*, 927 F.2d 505, 509 (10th Cir. 1991) (although the plaintiff was not seeking benefits under the employee benefit plan, the "factual basis for each of plaintiff's state law

claims directly concern[ed] the alleged improper administration of the benefit plan;" therefore, plaintiff's claims were preempted because they "relate[d] to" an employee benefit plan covered by ERISA.); *Howard v. Parisian, Inc.*, 807 F.2d 1560, 1564 (11th Cir. 1987) ("[I]f a state law claim arises out of the administration of benefits under [an employee benefit plan], the claim is preempted" by ERISA.); *Powell v. Chesapeake & Potomac Tel. Co.*, 780 F.2d 419, 421 (4th Cir. 1985), *cert. denied*, 476 U.S. 1170 (1986) (holding that "state laws, insofar as they are invoked by beneficiaries claiming relief for injuries arising out of the administration of employee benefit plans, 'relate to' such plans and . . . are preempted by ERISA."); *Scott v. Gulf Oil Corp.*, 754 F.2d 1499, 1504 (9th Cir. 1985) ("[P]reemption of state law claims by ERISA depends *on the conduct to which such law is applied, not on the form or label of the law.*") (citations omitted).

Plaintiffs in this case do not make a direct claim for contractual benefits under the Group Medical Plan. However, plaintiffs are asserting claims that *arise from the administration of that Plan.*

Plaintiffs allege that Buddy Kuhl died as a result of defendant's cancellation of Kuhl's heart surgery. Specifically, plaintiffs allege that Buddy Kuhl was scheduled for heart bypass surgery at Barnes Hospital in St. Louis on July 6, 1989. On June 20 or 21, 1989, Lincoln National received a telephone call from Barnes Hospital requesting pre-certification review. In Lincoln National's judgment, the request did not satisfy requirements under the Plan for pre-certification because the surgery was to be performed by non-participating physicians at a hospital that was not associated with Lincoln National. Thus, Lincoln

National did not pre-certify payment but instead requested additional information in the form of a second medical opinion concerning the necessity of the surgery. Lincoln National admits, for the purpose of this motion, that its refusal to pre-certify had the effect of cancelling the July 6, 1989, surgery.

Plaintiffs argue that by taking these actions, Lincoln National tortiously interfered with the contractual relationship between Buddy Kuhl and his doctors. They also contend that Lincoln National is liable for medical malpractice because it assumed the role of Buddy Kuhl's physician by making decisions about proper medical treatment. Also, plaintiffs allege that Lincoln National intentionally inflicted emotional distress on Buddy Kuhl's wife because she was aware that Lincoln National "cancelled" Kuhl's surgery, was present when Kuhl was informed in December [sic] 1989 that his heart could no longer withstand surgery and that a transplant was his only option and was present when Kuhl collapsed and died while waiting for a heart to become available. Finally, plaintiffs allege that Lincoln National breached its contract with Belger, of which Buddy Kuhl was a third-party beneficiary, by refusing to pre-certify the surgery scheduled for July 6, 1989.

According to the normal meaning of the statutory words "relate to," each of plaintiffs' claims "has a connection with" the Plan or, more specifically, each claim "arises from the administration" of the Plan. Plaintiffs' claims are based on the manner in which Lincoln National responded to the request for "Pre-certification" of Buddy Kuhl's heart surgery. Artful pleading by characterizing Lincoln National's actions in refusing to pay for

the surgery as "cancellation" or by characterizing the same administrative decisions as "malpractice" does not change the fact that plaintiffs' claims are based on the contention that Lincoln National improperly processed Kuhl's claim for medical benefits. Thus, plaintiffs' claims "relate to" the Plan and are preempted by § 514(a).

Although Lincoln National admits that its refusal to pre-certify the surgery caused it to be cancelled, plaintiffs' claims would be preempted even if somebody else actually cancelled the surgery. When Lincoln National communicated to Barnes Hospital its refusal to pre-certify payment of Kuhl's medical expenses for the surgery, the surgery was cancelled by someone, most likely Barnes Hospital. This cancellation was a direct result of Lincoln National's administration.

This conclusion is supported by the sound reasoning of the court in *Holmes v. Pacific Mutual Life Insurance Co.*, 706 F. Supp. 733 (C.D. Cal. 1989), which involved a factual situation very similar to this case. There, the plaintiff was a participant in an employee medical benefit plan that was covered by ERISA and administered by the defendant. The plaintiff developed a life-threatening liver disorder for which a liver transplant was the only cure. Arrangements were made for the transplant surgery to be performed at the UCLA Medical Center. When the UCLA Medical Center asked the defendant whether the medical benefit plan covered the cost of the surgery, the defendant erroneously stated that it did. After tentative arrangements for surgery were made, the plaintiff was required to wait until a transferable liver was located. When a liver became available, the UCLA Medical Center again called the defendant to verify that the plan covered

the cost of the surgery. At that time, the defendant correctly answered that it did not and the surgery was cancelled. The plaintiff then determined that she had other medical coverage and again made arrangements for surgery, but, before another suitable liver was found, she died. *Id.* at 734.

The plaintiff filed a petition in state court asserting various state law claims. The defendant removed the case to federal district court based on federal question jurisdiction under ERISA. The plaintiff then sought remand urging that there was no ERISA claim stated in the petition. The defendant then moved for summary judgment on the ground that ERISA preempted the plaintiff's state law claims because they were based entirely on representations made by the defendant acting in its capacity as the plan administrator. *Id.*

The court held that the plaintiff's state law claims were preempted because they were caught within the "sweep" of ERISA. In reaching this holding, the court noted that ERISA preemption is designed to shield ERISA employee benefit plans from unforeseen liabilities, including liabilities arising from claims such as the plaintiff's. *Id.* at 735. The court also stated that "were it not for the decision in *Pilot Life,* it might be argued that ERISA does not require preemption of [state law actions] against independent plan administrators since payments of liabilities would not come from the [plan's] fund nor appear at first blush to disturb [the] actuarial assumptions for funding [of the plan]." *Id.* at 36. However, the court noted that *Pilot Life* "wisely settled the principle that ERISA requires preemption of [state law] actions against plan administrators as well as [against] plans themselves.

Were this not the case, the ultimate cost of the liabilities imposed upon plan administrators inevitably would fall back on employers and the plans they sponsor." *Id.* at 36 & n.7. Such a result would neutralize the protection that the ERISA preemption provision provides to employers.

Plaintiffs rely heavily on cases holding that certain types of claims are too tenuous or too remote to warrant preemption. However, because none of those cases involve the types of claims asserted in this case, they are not persuasive.[4]

Plaintiffs also rely on *Drinkwater v. Metropolitan Life Insurance Co.*, 846 F.2d 821, 825 (1st Cir. 1988), *cert. denied*, 488 U.S. 909 (1988), to support their emotional distress claim. The court in *Drinkwater* stated in dicta that a wife's claim for emotional distress which resulted from an administrator's denial of benefits to her husband under an ERISA-covered plan was not preempted by ERISA. The court nevertheless granted the defendant's summary judgment motion because the plaintiff failed to show that she suffered physical injury, a necessary element of an emotional distress claim.

I am not persuaded by *Drinkwater* because there is ample, well-reasoned caselaw that directly contradicts it. *See, e.g., Johnson v. District 2 Marine Engineers Beneficial Assoc.*, 857 F.2d 514, 517-18 (9th Cir. 1988); *Powell v. Chesapeake & Potomac Tel. Co.*, 780 F.2d 419 (4th Cir. 1989), *cert. denied*, 476 U.S. 1170 (1990). Furthermore, the court's conclusion in *Drinkwater* does not apply in this case. Here,

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[4] These cases are referred to *supra* p. 14.

plaintiffs' alleged emotional distress claim arises *directly* from Lincoln National's *administration* of Plan.

Thus, I conclude that all of plaintiffs' claims are preempted under § 514(a). Unless these claims are within the scope of § 502(a) of ERISA, they must be dismissed.

2. Plaintiffs' claims are not "within the scope" of § 502 (a) of ERISA

Section 502(a) of ERISA, 29 U.S.C. § 1132(a), provides:

> A civil action may be brought –
>
> (1) by a participant or beneficiary –
>
> (A) for the relief provided for in subsection (c) of this section, or
>
> (B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan;
>
> (2) by the Secretary, or by a participant, beneficiary or fiduciary for appropriate relief under section 1109 of this title;
>
> (3) by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provisions of this subchapter or the terms of the plan, of (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan;

> (4) by the Secretary, or by a participant, or beneficiary for appropriate relief in the case of a violation of 1025(c) of this title;
>
> (5) except as otherwise provided in subsection (b) of this section, by the Secretary (A) to enjoin any act or practice which violates any provision of this subchapter, or (B) to obtain other appropriate equitable relief (i) to redress such violation or (ii) to enforce any provision of this subchapter; or
>
> (6) by the Secretary to collect any civil penalty under subsection (i) of this section.

The subsection that is most applicable to this case is § 502(a)(1)(B).[5]

The allegations in plaintiffs' Complaint and the facts presented in connection with the summary judgment do not suggest that plaintiffs seek to recover benefits due under the terms of the group medical plan, to enforce Buddy Kuhl's rights under the plan at the time pre-certification approval was sought or to clarify Kuhl's rights to future benefits under the terms of the plan.

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[5] Section 502(a)(1)(A) is not applicable because subsection (c) provides for suing a plan administrator if the administrator fails to furnish requested information. Sections 502(a)(5) and 502(6) are not applicable because civil actions may be brought under those sections only by the Secretary of Labor. Section 502(a)(2) does not apply because plaintiffs do not allege any claims against defendant based on breach of duty under 29 U.S.C. § 1109. Section 502(a)(3) is not relevant because plaintiffs do not seek equitable relief. Section 502(a)(4) is also not applicable because plaintiffs do not seek relief for defendant's failure to furnish information in defendant's Internal Revenue Service registration statement.

Accordingly, plaintiffs' claims are not within the scope of § 502(a).

IV. Conclusion

Because plaintiffs' claims are preempted by ERISA, plaintiffs' Motion to Remand will be denied. Also, because plaintiffs' claims are preempted by ERISA but do not fall within the scope of § 502(a), this court has no authority under ERISA to consider plaintiffs' claims. Thus, defendant's Motion for Summary Judgment will be granted.

V. Order

For the foregoing reasons, it is ordered that:

1) plaintiffs' Motion to Remand is denied;

2) defendant's Motion for Summary Judgment is granted and summary judgment is entered in favor of defendant and against plaintiffs; and

3) this case is dismissed.

/s/ D. Brook Bartlett
D. BROOK BARTLETT
UNITED STATES DISTRICT JUDGE

Kansas City, Missouri
December 26, 1991.

United States District Court
WESTERN DISTRICT OF MISSOURI

Mary Kuhl, et al.,

Plaintiffs,

V.

Lincoln National Health Plan of Kansas City, Inc.,

Defendant.

JUDGMENT IN A CIVIL CASE

(Filed Dec. 26, 1991)

CASE NUMBER: 91-0330-CV-W-9

— **Jury Verdict.** This action came before the Court for a trial by jury. The issues have been tried and the jury has rendered its verdict.

X **Decision by Court.** This action came to /consideration before the Court. The issues have been /considered and a decision has been rendered.

IT IS ORDERED AND ADJUDGED

1) plaintiffs' Motion to Remand is denied;

2) defendant's Motion for Summary Judgment is granted and summary judgment is entered in favor of defendant and against plaintiffs; and

3) this case is dismissed.

December 26, 1991
Date

R. F. Connor
Clerk

/s/ Tina Duer
(By) Deputy Clerk